# Direct Member Reimbursement Form - Medical

Last revised: July 2026

CareOregon Advantage

CareOregon Advantage's policy for medical services is to pay the provider, and the provider is responsible for reimbursing the member. In some cases, when the provider refuses to bill CareOregon Advantage, we can reimburse members up to the allowed amount. We do not reimburse for non-covered services. Members will work with Customer Service to submit bills to CareOregon Advantage.

Before submitting this form, please contact CareOregon Advantage Customer Service toll-free at 888-712-3258. Also, check that the information on this form is complete and legible. If the decision for reimbursement is favorable, you will receive a notice and payment within 30 days from the date that we receive the request.

## What to include

To help us process the request, please include the following:

1. Call tracking ID number, provided by Customer Service (optional): _____
2. Proof of payment
3. Itemized bill with the following information:
   - Patient name
   - Provider name, address, phone, and National Provider Identifier (NPI)
   - Date services were rendered
   - Types of services provided (REV/CPT/HCPCS)
   - Patient health record number
   - Patient account number
   - Diagnosis/reason for visit
   - Charge for each service

## Reason for request

Please select the reason for this reimbursement request:

☐ No insurance card at the time of service ☐ Provider was out of area/network

☐ Other: _____

## Member information

First name: _____ Last name: _____

Date of birth: _____ Phone number: _____ Gender: _____

Member ID: _____ Address: _____

City: _____ State: _____ ZIP code: _____

If you are filling out this form for a member, please enter your details below:

Name: _____

Relationship to member: _____ Phone number: _____

Address: _____

## Signature

By signing this form below, I certify that all information provided on this form is correct to the best of my knowledge; the services that were rendered were for the CareOregon Advantage member on a date that patient was eligible. I am the member or authorized person completing this form and I authorize release of any pertinent information from the provider that is necessary to expedite the processing of said claim to CareOregon Advantage and I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties.

Signature: _____ Date: _____

## For CareOregon use only

Received _____ ☐ Provider paid ☐ Approved ☐ Denied ☐ Cancel/member ineligible

Eligibility: _____ LOB: _____ Duplicate claim: _____ Uploaded to OneCo: _____ Other: _____



315 SW Fifth Ave, Portland, OR 97204 • 888-712-3258 • careoregonadvantage.org